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March 2007

State of Arizona, Department of Economic Security, Comprehensive Medical and Dental Program

PROVIDER REVIEW

April is Child Abuse Awareness Month
April 2007

Most child abuse occurs within the home involving a person or persons that the child knows. The best prevention for child abuse is community awareness and intervention.

Examples of Abuse are:

- **Physical Abuse** - may be a result of punching, beating, kicking, biting, burning, shaking or otherwise physically harming a child. The parent or caretaker may not have intended to hurt the child; rather, the injury may have resulted from inappropriate discipline or physical punishment.
- **Child Neglect** - may be characterized by failure to provide for the child's basic physical, emotional and educational needs. Some examples are:
  - Children who appear to be malnourished.
  - Children inappropriately clothed for the weather.
  - Children have untreated illnesses or injuries.
  - Children living in a home which has health or safety hazards.
  - Children who are abandoned or not supervised appropriately and may be in danger due to lack of supervision.
- **Sexual Abuse** - may include rape, touching & fondling a child, or involving a child with pornography. Children who report sexual interaction with a parent, caretaker or who exhibit symptoms may be sexual abused.
- **Emotional Abuse**—may include acts or omissions by the parents or other caregivers that have caused, or could cause, serious behavioral, cognitive, emotional or mental disorders.
- **Shaken Infant Syndrome:** Vigorous shaking of a child under the age of two years old may cause severe brain injury or death.

The reasons for not reporting abuse include not knowing where to call and misconceptions regarding what will happen once a report of known or suspected abuse is made to the police or a child protective services agency. Many people incorrectly believe that:

- by law, abused children must be removed from their homes immediately, which is the least likely outcome.
- child abuse cannot be reported anonymously. In most states, you don't need to provide your name.
- the person reported for abuse is entitled to know who made the report. They are not.

For other reporting numbers in your area, call the Childhelp USA® National Child Abuse Hotline at 1-800-4-A-CHILD® (1-800-422-4453). The hotline is staffed by degreed professionals 24 hours a day who accept calls from the United States, Canada, Guam, Puerto Rico and the U.S. Virgin Islands. Calls are anonymous and toll-free. State-of-the-art technology provides translators in 140 languages. For additional information please contact CMDP at (602) 351-2245 or (800) 201-1795 Ext 13770.

If you are working with children or families in any capacity, you *must* report suspected abuse or neglect to either law enforcement or Child Protective Services. (ARS 13-3620). SUSPECT ABUSE, REPORT IT. NOW! 1-888-SOS-CHILD (1-888-767-2445)

Just a Click Away!!!

You can now check CMDP's Claims Status or Member Eligibility on Line at the CMDP/DES website, **www.azdes.gov**.

You will need the Member's CMDP ID number, your AHCCCS Provider ID number and the Dates of Service you are verifying eligibility.

Once you have logged into the web site:

- Click **MEDICAL** (Left side of screen) for a drop-down menu
- Click on **Comprehensive Medical and Dental**. This will bring you to the CMDP website.
- Click PROVIDER SERVICES (Left side of screen).
- From here it gives you the option to choose either the Claims Lookup or the Members Lookup. Once you have selected either one of these options follow the step-by-step directions.

You can also verify eligibility via e-mail.

Member Services e-mail addresses:

MariaVillanueva@azdes.gov

LMoore@azdes.gov

RosemaryCelaya@azdes.gov

For further assistance with either member eligibility or claims status, please contact the Member Service Unit. If you need assistance with claims, please contact the Claims Unit. For general information in navigating through these systems, please contact your Provider Representative. All three of these units can be reached at (602) 351-2245 or (800) 201-1795.

IMPLANON Billing…..

Implanon is an implantation birth control method similar to Norplant. Implanon is a CMDP covered benefit, however this procedure requires prior authorization by CMDP. When billing for these procedures J3490 should be used for the medication and procedure codes 11975 and 11977 are for insertion and re-insertion.

If you have any questions regarding submitting a claim, please contact the Provider Services Unit. If you have any questions regarding CMDP coverage of birth control, please contact the Medical Services Unit and speak with the CMDP Maternal Health Coordinator.

New ADA Claim Form for NPI

The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan. ADA policy promotes use and acceptance of the most current version of the ADA Dental Claim Form by dentists and payers.

The latest version of the dental claim form enables reporting of a National Provider Identifier (NPI), in addition to a current proprietary provider identifier, for both the Billing Dentist/Dental Entity and for the Treating Dentist. **This version of the form becomes valid for use on January 1, 2007.**

Three samples of the ADA Dental Claim Form are available for your review. Go to the website listed to attain the copies: www.ada.org/prof/resources/topics/claimform.asp

Getting an NPI is free - Not Having One Can Be Costly.

Only 2 months remain until the National Provider Identifier (NPI) compliance date of May 23, 2007 is upon us. Health care providers can apply for NPI's in one of the following:

- http://www.cms.hhs.gov/NationalProvIdentStand
- Phone: (800) 465-3203 or TTY (800) 692-2326
- E-mail: customerservice@npienumerator.com
- Mail: NPI Enumerator, P.O. Box 6059 , Fargo, ND 58108

If you are a health care provider who bills for services, you probably need an NPI. If you bill Medicare for services, you definitely need an NPI!

Please be advised that an NPI number must be provided to CMDP by May 22, 2007. Otherwise, your claim submitted on or after May 23, 2007 will be denied.

Getting an NPI is easy. Getting an NPI is free. The first step is to get your NPI. Once you obtain your NPI, fax notification to Provider Services at (602) 264-3801.

For additional information please visit the following websites

- http://azahcccs.gov/HPlans&Providers/
- http://www.cms.hhs.gov/NationalProvIdentStand
- or call CMDP Provider Services at (602) 351-2245 or (800) 201-1795.

Deficit Reduction Act – False Claims Act
Staff Training Sites

AHCCCS is requiring all contractors to train their staff on the following aspects of the Federal False Claims Act provisions:

- The administrative remedies for false claims and statements;
- State laws relating to civil or criminal penalties for false claims and statements; and
- The whistleblower protections under such laws.

In an effort to assist our providers in this staff training requirement, David Botsko, PhD., CFE, Director Office of Program Integrity, AHCCCS, has created a web based training of the required information located at www.ahcccs.state.az.us/PlansProviders/DRATraining/DRATraining/index.htm.

Please amend your staff training requirements to include the required information in whatever format you determine best. Thank you for your continuing dedication to the foster children of Arizona.

What You Need to Know About Vaccine Management Business Improvement Project

CMDP is working with the Arizona Immunization Program Office to ensure all Vaccines for Children (VFC) Providers are appraised of vaccine ordering changes that will take place beginning April 30, 2007. The new process is called "VMBIP" (Vaccine Management Business Improvement Project).

- **What is VMBIP?**
  It is a new nationwide vaccine ordering system that will centralize and streamline the current VFC vaccine ordering process for the federal VFC Program and other vaccine programs.

- **Why is VMBIP necessary?**
  The current state-by-state system is cumbersome and expensive to manage. VMBIP will be more cost-effective by centralizing vaccine storage and distribution; allowing for rapid response to changes in vaccine supply; and generating more consistent levels of vaccine accountability

- **How will it affect each provider?**
  The primary changes will begin on April 30, 2007 and will include:

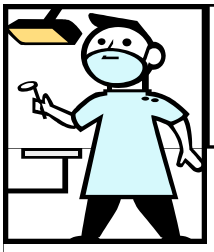
  - A change in the vaccine distributor – you will receive VFC vaccine from McKesson (who may use different packaging). You will no longer receive VFC vaccine from General Injectables and Vaccines (GIV).
  - How frequently you place your VFC vaccine order will depend upon the number of doses you order annually. Example: practices designated as "Medium Volume" (500-1,999 doses/year) will be on a bi-monthly (every two months) ordering schedule.

- **How do I know how often to order vaccine?**
  You will receive a letter in March from the Arizona Immunization Program Office, Vaccine Center, indicating the frequency and months to order vaccine. The AZ VFC staff will work with you to establish an efficient and routine ordering pattern.

- **Will there be other changes?**
  Yes, AIPO will implement an electronic vaccine ordering system using ASIIS. Such a system will facilitate online, real time vaccine inventory, management and ordering, eliminating most paper forms. This system is anticipated in late 2007. Providers who do not have computer systems will continue to use paper forms and fax.

- **Who do I call if I have any questions?**
  You will continue to call the AZ Vaccine Center at (602) 364-3642 for assistance with any questions/ issues. More information on VMBIP can be found at: www.cdc.gov/nip/vmbip/default.htm.

CMDP and the Arizona Immunization Program Office look forward to working with you during this transition.



DR. C says…… "The Oral Cavity—Signs of Child Abuse"

By Dr. Jerry Caniglia, Dental Consultant

In approximately 65% of physical abuse cases reported, there were injuries to the head, neck, or facial areas. The oral cavity is a frequent site of abuse in children. Physicians in general receive minimum training in oral health disease and dental injury and therefore may not be able to easily recognize and detect dental aspects of abuse and neglect as readily as child abuse and neglect involving other areas of the body. Therefore, physicians should consult with dentists if abuse is suspected that involves the oral cavity and surrounding facial areas. The most commonly found oral injuries and those surrounding the mouth are contusions and lacerations to the gingival tissues and attached frenum; lacerations to the tongue, hard and soft palate, or buccal mucosa; displaced, fractured or avulsed teeth; or trauma to lips and corners of the mouth.

Dental neglect is when a parent or guardian willfully fails to have necessary dental care initiated or completed after being informed of the nature and severity of the dental condition. Dental neglect occurs when the parent knowingly is aware that the child's condition, if not completed, results in pain and infection and compromise of normal and adequate function. Since the oral cavity may be the focus of physical abuse and dental neglect, it is essential that the physician and dentist communicate and discuss clinical findings when evaluating suspected conditions. Professional collaboration efforts will increase the recognition and the reporting of suspected cases of child abuse to law enforcement and the appropriate social service agencies.

Promoting Culturally Sensitive Health Care

Cross-cultural education and training for health care professionals can build a solid foundation to improve quality of care and reduce health care disparities among our nation's growing diverse population. American Health Insurance Plans (AHIP) is laying the groundwork for action by launching a free, interactive e-learning program for physicians.

Quality Interactions℠: A Patient-Based Approach to Cross-Cultural Care is a one hour, continuing medical education (CME) course designed for physicians. The course provides physicians and clinicians with the tools and skills to communicate more effectively with patients from diverse backgrounds. The course provides an interactive case study of an African American male with asthma. Its patient-based approach takes into account the individual's cultural perspectives and preferences.

AHIP also provides an **introductory/mini-case vignette** on cross-cultural care for health care professionals. The abbreviated version of the *Quality Interactions℠* course hopes to stimulate interest in the area of cultural competency to better serve America's racial and ethnically diverse populations and improve overall quality of care. AHIP's introductory/mini-case vignette does not offer CME credits. Please Note: Physicians/Clinicians will need an Organization ID to register for AHIP's **one hour CME** course. If you have forgotten your Organization ID or your password, please e-mail QIModule@ahip.org.

Birth to Five Helpline (877) 705-KIDS (877) 705-5437

Operated by Southwest Human Development's Arizona Institute for Early Childhood Development, the Birth to Five Helpline is a toll-free answer line for parents, caregivers and professionals. Early childhood development specialists, registered nurses, disabilities specialists, early literacy specialists, and mental health counselors are available to answer questions about children ages birth to five focusing on the basic child development information families need.
Topics include health, nutrition, child development, sleep, discipline, safety, learning to read, and getting ready for kindergarten. Currently the Helpline is staffed from 8am-8pm Monday through Friday and 10am to 2pm on Saturday. For more information about Southwest Human Development, visit www.swhd.org.

2600 N. Central Ave. Suite 740
Phoenix, AZ 85004
(602) 265-1950
Fax: (602) 532-0139
phoenixoffice@azaap.org

Infant Deaths Associated with Cough and Cold Medications

Cough and cold medications that contain nasal decongestants, antihistamines, cough suppressants, and expectorants commonly are used alone or in combination in attempts to temporarily relieve symptoms of upper respiratory tract infection in children aged <2 years. However, during 2004–2005, an estimated 1,519 children aged <2 years were treated in U.S. emergency departments for adverse events, including overdoses, associated with cough and cold medications. In response to reports of infant deaths after such events, CDC and the National Association of Medical Examiners (NAME) investigated deaths in U.S. infants aged <12 months associated with cough and cold medications. This report describes the results of that investigation, which identified the deaths of three infants aged <6 months in 2005, for which cough and cold medications were determined by medical examiners or coroners to be the underlying cause. The three infants ranged in age from 1 to 6 months; two were male. All three infants had what appeared to be high levels of pseudoephedrine (a nasal decongestant) in postmortem blood samples. One infant had received both a prescription and an over-the counter cough and cold combination medication at the same time; both medications contained pseudoephedrine. The other two infants also had received pseudoephedrine containing medications (one prescription and one over the counter). Two of the infants had been administered prescription medications containing carbinoxamine (an antihistamine), although neither had detectable postmortem blood levels of carbinoxamine. Two of the infants had detectable blood levels of dextromethorphan (a cough suppressant) and acetaminophen (an antipyretic and analgesic). All three infants were found dead in their homes. Autopsy and medical investigation records were obtained. A medical examiner or coroner determined that cough and cold medication was the underlying cause of death for each of the three. None of the deaths were determined to be intentional. On autopsy, two of the infants had evidence of respiratory infection; no abnormalities in cardiac pathology were revealed in any of the infants. However, in this report, the blood levels of pseudoephedrine found in the three patients aged 1–6 months were approximately nine to 14 times the levels resulting from administration of recommended doses to children aged 2–12 years.

The dosages at which cough and cold medications can cause illness or death in children aged <2 years are not known.

Food and Drug Administration (FDA)-approved dosing recommendations for clinicians prescribing cough and cold medications do not exist for this age group. Because of the risks for toxicity, absence of dosing recommendations, and limited published evidence of effectiveness of these medications in children aged <2 years, parents and other caregivers should not administer cough and cold medications to children in this age group without first consulting a health-care provider and should follow the provider's instructions precisely. Clinicians should use caution when prescribing cough and cold medications to children aged <2 years. Moreover, clinicians should always ask caregivers about their use of over-the-counter combination medications to avoid an overdose in children from multiple medications that contain the same ingredient. In addition to advising caregivers and health-care providers regarding the risks of administering cough and cold medications to children aged <2 years, public health officials have taken steps to improve the safety of these medications. On June 8, 2006, The FDA took enforcement action to stop the manufacture of carbinoxamine-containing medications that had not been approved by the agency. The FDA noted that many of the medications were inappropriately labeled for use in infants and young children despite safety concerns regarding use of carbinoxamine in children aged <2 years (*9*). Although manufacturers were required to cease production by September 6, 2006 some products might still be in distribution. In another action, the availability of pseudoephedrine containing medications has been affected by the federal Combat Methamphetamine Epidemic Act, which was signed into law March 9, 2006. This act bans over-the-counter sales (but permits behind-the-counter sales in limited amounts) of cold medications that contain pseudoephedrine, which can be used to make methamphetamine. Because of this act, pseudoephedrine has been removed as an ingredient in many cough and cold medications and replaced with other nasal decongestants. However, some pediatric cough and cold medications containing pseudoephedrine still might be sold behind the counter.

As an alternative to pseudoephedrine and other nasal decongestants, caregivers might consider clearing nasal congestion in infants with a rubber suction bulb. Secretions can be softened with saline nose drops or a cool-mist humidifier.

Performance Improvement Project 2007

CMDP in collaboration with AHCCCS will be implementing a new Performance Improvement Project (PIP) in CYE 2007. The PIP topic is "Improving the Use of Appropriate Medications for People with Asthma." You will be provided with more detailed information as the project progresses. CMDP may be contacting your office for additional information on your pediatric patients with asthma.

HEADS UP on Immunizations!

We would like to remind you how important it is to make sure all children in our care are immunized timely. It is also vitally important that those immunizations be recorded in the ASIIS system. Providers are required to document all immunizations in the ASIIS system. CMDP accesses the ASIIS system to retrieve immunization records and immunization forecasts for the foster child's case manager. Many times, when providers are contacted to bring the children's immunizations up to date, (based on ASIIS information), CMDP is told that the immunizations, in most cases, are current. It is especially important with foster children that the ASIIS system be updated because foster children frequently change residences and providers. ASIIS then becomes the main source of information regarding the children's immunization status.
The process for entering information into the ASIIS system is simple and quick; it only takes a couple of minutes to update the information. If you need additional information or training on ASIIS please call (602) 230-5894 in Phoenix or toll-free at (877) 491-5741 outside of Phoenix for training class locations and times. This training is free.

Also, we would like to notify you that the AHCCCS Immunization Audit is coming up in October/November. CMDP's staff may be calling your offices to request up to date immunization records on selected 2 year olds be faxed to us. Your cooperation in this audit is greatly appreciated. If you have any questions, please feel free to contact our Medical Services Unit and speak with the EPSDT nurse.

Teen Suicide Spike Linked to SSRI Black Box

Teen and childhood suicides rose sharply in 2004, for the first time in more than 10 years, and some are linking this to a reduced use of antidepressants that year because of black box label warnings mandated by the FDA. According to figures compiled by the CDC there were 1,985 suicides among those ages 10 through 19 in 2004, compared with 1,737 in 2003. That's a rate of 2.6 per 100,000, up from 2.2 per 100,000 the year before, according to the *Annual Summary of Vital Statistics*, published in the February issue of *Pediatrics*.

Overall, the death rate from suicide increased by 18.2% -- a change that was deemed "unacceptable" by David Shern, Ph.D., president of Mental Health America. Dr. Shern said it's premature to draw conclusions about the cause of the increase, but noted that it coincided with the FDA's warning that selective serotonin reuptake inhibitors (SSRIs) had been linked to suicidal thoughts in young people. The warnings created a barrier to treatment "by scaring young people and parents away from care" that may be linked to the rise in suicide, Dr. Shern said in a statement. Charles Nemeroff, M.D., Ph.D., of Emory University School of Medicine told reporters he has no doubt that the warning contributed to the suicide increase. "The concerns about antidepressant use in children and adolescents have paradoxically resulted in a reduction in their use, and this has contributed to increased suicide rates," Dr. Nemeroff said. Noting that the adolescent suicide rate had been falling, David Fassler, M.D., of the University of Vermont in Burlington, Vt., called the new data "very disturbing." "The sudden increase in the adolescent suicide rate," Dr. Fassler told reporters, "corresponds to the significant and precipitous decrease in the use of SSRI antidepressants in this age group." He said there are no data showing that SSRIs increase the risk of suicide and "the current data suggest that the decreased use of these medications is, in fact, associated with an increase in actual deaths attributable to suicide." But the warnings may not be the only reason for the spike, according to Bernadette Melnyk, Ph.D., R.N., of Arizona State University in Phoenix. She told reporters the U.S. is short about 30,000 child psychiatrists "so the gaps in mental health services for those children and youth who need them are huge." She said that one in four teens has a mental health problem and only about a quarter of them are treated.

If you have any questions or cases to discuss, please contact our Behavioral Health Coordinators within the Medical Services Unit for assistance.

By Michael Smith, Senior Staff Writer, MedPage Today
February 06, 2007

Alarm Treatment Preferred Method for Treating Childhood Enuresis

Nocturnal enuresis, bed wetting at age 5 years or older, occurs in 13% to 19% of boys and 9% to 16% of girls with persistence in 2% to 3% of adolescents and adults. Possible etiologies include delay in attaining bladder control, difficulty with arousal, nocturnal polyuria, or small nocturnal bladder capacity. Treatments include enuresis alarm training or pharmacologic, simple behavioral, complex behavioral, and complementary and miscellaneous measures. "Nocturnal enuresis is a common childhood disorder that is characterized by bed wetting at the age of five and beyond," write Kelly Russell, MD, and Darcie Kiddoo, MD, from the University of Alberta in Edmonton, Canada. "The proposed etiologies are difficulties with arousal, nocturnal polyuria or a small nocturnal bladder capacity, although the most common is probably simple developmental delay in achieving bladder control. Therapies attempt to address these etiologies individually." Although nocturnal enuresis spontaneously resolves in about 15% of children each year, 2% to 3% of adolescents and young adults will continue to wet the bed.

Enuresis alarms are the preferred method of treating childhood enuresis, according to the results of an evidence-based Cochrane review reported in the June issue of *Evidence-Based Child Health*.

- In children with nocturnal enuresis, enuresis alarms are the most effective method for decreasing the number of wet nights and preventing relapse.
- In children with nocturnal enuresis, desmopressin and tricyclics effectively reduce the number of wet nights but do not prevent relapse. Limited evidence is available on the efficacy of other drugs, simple and complex behavioral interventions, and complementary and miscellaneous interventions.

Available treatments of nocturnal enuresis include training with alarms activated by micturition; pharmacologic agents, including desmopressin and tricyclic antidepressants; simple or complex behavioral measures; or complementary and miscellaneous treatments. When compared with a placebo or with no treatment, enuresis alarms resulted in approximately 3 more dry nights per week. When compared with a placebo, any dose of desmopressin resulted in more dry nights. There was no evidence for sustained effectiveness of desmopressin once the treatment was completed, and the effectiveness of adding an alarm to desmopressin treatment was unclear. Similarly, evidence was insufficient to determine the effectiveness of desmopressin vs. behavioral interventions (retention control training with or without psychological therapy) or laser acupuncture. The adverse events of desmopressin were generally mild. Wet nights were significantly fewer, and relapse rates were lower with reward systems, lifting, and waking. Simple behavioral interventions appear to be safe, but they are labor intensive. Evidence is insufficient to determine the effectiveness of retention control training. "In this umbrella review, the bed alarm was found to have the greatest evidence of success," the authors write. "In practice it is difficult for patients and families to persevere and see the benefits of the alarm.... However, if encouraged and properly instructed, families will work together to wake the child with the alarm and eventually the child will succeed."

The authors note that improvement with desmopressin was not as great as with the bed alarm, most likely due to varying reasons for nocturnal enuresis. The tricyclics "are losing favor with most physicians" because of the potential for overdose and the less than promising results. Despite promising evidence for other drugs, such as indomethacin, diclofenac, and diazepam, adverse effects are a concern. "It appears that enuresis alarms are the most efficacious method for not only decreasing the number of wet nights, but also for preventing relapse once alarm treatment has ceased," the authors conclude. "Among the pharmacological interventions, desmopressin and tricyclics are better than a placebo at reducing the number of wet nights. This effect was not sustained after cessation of desmopressin or tricyclics."

GARDASIL

GARDASIL is given as 3 injections over 6 months.

* First dose: At a date you and your doctor or healthcare professional choose
* Second dose: 2 months after the first dose
* Third dose: 6 months after the first dose

Per New 2007 Immunization Schedule:

* The new human papillomavirus vaccine (HPV) is recommended in a 3-dose schedule with the second and third doses administered 2 and 6 months after the first dose. Routine vaccination with HPV is recommended for females aged 11-12 years; the vaccination series can be started in females as young as age 9 years; and a catch-up vaccination is recommended for females aged 13-26 years who have not been vaccinated previously or who have not completed the full vaccine series.

Effects of Smoking on Health

More than 45.4 million American adults (21.6%) are smokers. Especially concerning are the rates among teens. In a recent survey, 22.3% of high school students admitted to smoking. Smoking costs the nation at least $167 billion in healthcare costs and lost productivity each year. In 2004, the Surgeon General reported, "Smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general."

Adverse effects of parental smoking on the respiratory health of children have been a clinical and public health concern for decades. As early as 1974, a possible link was established between parental smoking and the risk of lower respiratory illness among infants. Subsequently, many epidemiologic studies have associated parental smoking with respiratory diseases and other adverse health effect throughout childhood. The exposures covered include maternal smoking during pregnancy and afterward, paternal smoking, parental smoking generally, and smoking by others. In 1986, the evidence was sufficient for the U.S. Surgeon General to conclude that the children of parents who smoked had an increased frequency of acute respiratory illnesses (pneumonia, bronchitis, asthma and asthma attacks) and related hospital admissions during infancy. Also noted was that in older children, there was an increased frequency of cough and phlegm and some evidence of an association with middle ear disease. Also noteworthy was a correlation between slowed lung growth in children and parental smoking. There are an estimated 150,000 to 300,000 cases every year of infections in infants and children under 18 months of age, resulting in between 7,500 and 15,000 hospitalizations per year. Education of our members and their caregivers and families is a key component not only to reducing health care costs of smoking related illnesses, but also and most importantly to protect and improve the health of our youth.

CMDP's Preferred Medication List does list many smoking cessation medications. If you have any questions or would like to refer one of your patients to our Medical Care Coordination, please contact the Medical Services Unit at (602) 351-2245 or (800) 201-

CMDP Contacts:
(602) 351-2245 (800) 201-1795

MEMBER SERVICES:
To verify a member's eligibility, choose any of these options:
****Please have member's name, date of birth, date of service & ID #.**
CMDP offers our providers eligibility verification via

- **Phone (602) 351-2245, (800) 201-1795**
- **FAX (602) 264-3801**
- **Internet Website: www.azdes.gov/dcyf/cmdpe**

Phone: Option 1 for English, Option 2 –if you are calling from a providers office, then Option 1

PROVIDER SERVICES:
Option 1, Option 2, then Option 3
For all your concerns, Provider Services will assist you or direct you to the appropriate department.

CLAIMS:
Option 1, Option 2 then Option 2
For verification of claim status, please select the options listed above for a claims representative.

CLAIMS MAILING ADDRESS:
CMDP 942-C, PO BOX 29202, PHOENIX, AZ 85038-9202

MEDICAL SERVICES:
Option 1, Option 2 then :

Hospitalizations.....Option 7
Prior Authorizations:
Medical.....Option 5
Dental.....Option 4
Behavioral Health.....Option 6
Pharmacy.....Option 8

Please contact Medical Services with any questions regarding the medical needs of our members.

"Web Corner"

The following is a list of websites we recommend to assist your office. If there are any other websites you wish to add and share with other providers please contact Provider Services. We will add them to our next newsletter.

CMDP's Website: www.azdes.gov/dcyf/cmdpe
Your location for an updated:

- Provider Manual,
- Newsletters,
- Member Handbook,
- Preferred Medication List (PML)
- Forms
- Provider Directory
- Member Eligibility Verification
- Claims Status

UPDATED CAP FEE SCHEDULE, AHCCCS Provider Manual , EPSDT forms and more available at: www.azahcccs.gov
CHILDREN'S REHABILITATIVE SERVICES (CRS), information and referral forms: www.hs.state.az.us/phs/ocshcn/crs/index.htm
VACCINES FOR CHILDREN (VFC) Program: www.cdc.gov/nip/vfc/Provider/ProvidersHomePage.htm
Every Child by Two Immunizations: www.ecbt.org
ASIIS and TAPI: www.whyimmunize.org/us.htm
American Academy of Pediatrics: www.aap.org